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IN
OBSTETRIC PRACTICE.

BY
SAMUEL C. BUSEY, M.D.,
Washington, D. C.



[Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES
OF WOMEN AND CHILDREN, Vol. XX., September, 1887.]

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Some Rare Clinical Observations in Obstetric Practice.¹

THE title of an essay should indicate the subject-matter of discussion. In this important requisite, the above title is entirely wanting. It would have been impossible to have grouped together the following reports under one common heading other than some general statement that they were clinical observations in obstetric practice. They are presented for your consideration, not as unique cases, but as illustrations of some surprises which have caused me much embarrassment and some anxiety, and may contribute something as aids in the diagnosis and management of uncommon and unexpected complications of pregnancy and labor.

CASE I.—*A Caul-Sac Obstructing the Diagnosis of Position in Head Presentation.*

Mrs. E., pregnant for the third time, commenced to feel very slight pains during the early morning of July 13th (1879), but they were so trifling as not to attract serious attention. She had not expected to be confined prior to August 1st. At 10 A.M., the os only admitted the end of the index finger; the fetus was too high for the recognition of the presentation without the introduction of the hand into the vagina, which was not done. At 7 P.M., the os was dilated to about the size of a silver half-dollar. At this time the diagnosis of head presentation in L. O. A. position was made. At 11.30 P.M., the os had dilated to the size of a silver dollar and was dilatable. The bag of waters had formed and was protruding; the membranes felt thick and tough; and the pains were not vigorous. An hour later, the amniotic sac was ruptured and a free and copious discharge of fluid followed. To accomplish this I had, during an intermission of pain, passed the right index finger through the os and posteriorly (the patient lying on her left side) between the membranes and inner surface of the uterine wall, just far enough to feel the head, and at the moment of greatest tension of the sac the sharp edge of the finger

¹ Read before the Washington Obstetrical and Gynecological Society, March 18th, 1887.

nail was suddenly thrust against it by extending the partially flexed finger. The perforation was made directly opposite the anterior fontanelle. Immediately after the escape of the "waters," I could feel the fontanelle, follow the course of the sagittal suture, but could only reach the posterior fontanelle high in the left anterior direction. Flexion had not taken place, but the head being small and the pelvis roomy, interference was not deemed necessary, as I believed that as soon as the expulsive pains were sufficiently powerful the vertex would descend and rotate under the arch of the pubis. The pains changed in character and speedily increased in force. Soon after the exploration just referred to I discovered the condition which I have called a *caul-sac*. The index finger being introduced through the dilated os, came in contact with a sac extending from the posterior margin of the anterior fontanelle laterally around the parietal protuberances and backwards over the vertex concealing the posterior fontanelle. To the sense of touch the sac seemed to be filled with fluid. It became very tense during the pains, and during the intermissions was sufficiently so to prevent recognition of the sutures, bony margins, or posterior fontanelle; and had I not known that I had ruptured the amniotic sac, and discharged a considerable amount of fluid, I might have punctured a second time; but relying upon this fact I avoided any violence. No caput succedaneum could be felt; nor did the sac feel like the scalp distended with hydrocephalic fluid. The head was small and the labor was progressing satisfactorily. The vertex descended, rotated under the arch of pubis, and at 3 A.M. (14th) the head passed the vulva. Then the nature of the difficulty was discovered to be a hood consisting of a portion of the membranes which covered the entire vertex, extending laterally and posteriorly, as previously described, between which and the underlying scalp was interposed a quantity of amniotic fluid. This hood I removed before the trunk of the child was delivered. At what stage of the progress of the head through the maternal passage the caul separated from the remaining portion of the secundines I cannot determine; but the secondary sac was recognized during the passage of the head through the parturient outlet, and was not understood until after the head had escaped and was examined *in situ*.

The formation of the secondary sac was undoubtedly due to the location of the puncture in the amniotic sac. As a rule, spontaneous rupture of the membranes takes place in the part protruding through the os, most frequently at or about the most dependent part or apex of the bag of waters, because at this point the pressure force of the compressed liquid is greatest and the resistance least. I have never witnessed the expulsion of an ovum "at term" with the membranes intact; nor would I permit such a delivery to occur, if avoidable. I have, how-

ever, very often encountered persistent membranes which delayed delivery. When to interfere in such cases is a very important question. Too early evacuation of the liquor amnii retards dilatation of the os, prolongs labor, intensifies the suffering of the woman, increases the risks of the fetus, and augments the difficulties and dangers of efforts to correct transverse and other abnormal presentations. Protracted persistence of the membranes wastes uterine power, lessens its propulsive force, delays retraction of the cervix, and may prevent the engagement of the presenting part in and its escape through even a softened and dilatable os. The tensile strength of the membranes (Duncan) varies from four to thirty-seven and a half pounds. The propulsive force which bursts the bag of membranes is frequently, in natural labors, quite sufficient to complete delivery; hence it is obvious (Duncan) that in many such labors the ovum would be expelled with membranes entire if artificial rupture had not been accomplished. In those cases of persistent membranes where the tensile strength is at or near its maximum, or even above the average, it is equally obvious that delivery is delayed, and there is an unnecessary expenditure of uterine force with consequent exhaustion, which is proportionate to the duration of the persistence of the bag of waters and condition of the patient. In no case ought the bag be permitted to advance in its integrity beyond the external surface, and in many cases an earlier discharge of the waters will be expedient. The puncture of the bag should always be made at or as near as may be convenient to the centre of the convex portion. The tear does not, however, even when spontaneous, always take place at the most dependent part in the vaginal pouch, or even external to the os. When located high within the os, there may be persistence of the bag of waters notwithstanding the gradual discharge of the liquor amnii. Spontaneous rupture usually occurs at the beginning of the second stage of labor.

CASE II.—An Elongated and Protruding Bag of Waters Obstructing Diagnosis of Presentation.

Mrs. D. was delivered of her second child April 13th, 1873. At my first visit, I did not make a diagnosis of the presentation, but simply satisfied myself that labor had begun. At my second visit, made several hours later, I was astonished to find, protruding from the vulva, an elongated and tense sac terminating in an irregularly shaped enlargement. This bag of waters I could trace up to and within the os uteri, where it was again expanded

into a roundish and larger tube. Between this point and the distal and protruding extremity its calibre was much smaller. The os was dilated to about the size of a silver dollar and dilatable. I knew the pouch was the bag of waters, but I could not determine the cause of its peculiar shape. I did not attempt to make a diagnosis of the presentation by the introduction of the finger into the uterus, because I feared to prematurely rupture the membranous bag, and could not, either by inspection or palpation, ascertain its contents beyond the fact that it was fluid. After waiting some time, perhaps an hour, and no change having taken place, I punctured the membranes, and then, to my great surprise, discovered that I was dealing with a presentation of the right foot. The other foot was brought down and delivery accomplished as usual.

This observation suggested the inquiry into the diagnostic value of the size and contour of the bag of waters in the determination of the presentation. I pursued this investigation for a while, but it did not promise much beyond the general statement that its size and shape were as much dependent upon the condition of the os, amount of liquor amnii, tensile strength of the membranes, and power of uterine contraction as upon the presenting part of the fetus. In head and breech presentations the membranous bag is more or less hemispherical, and more or less regular in contour, according to the presence and extent of lacerations of the cervix and shape of the os. In breech cases, the bag is usually less tense but more voluminous than in head presentations, because of the imperfect closure of the lower uterine segment; and when the os is rigid, it may be elongated. In cases of extension of an extremity with persistence of the membranes, there would be an elongation of the pouch, and the shape of the most dependent part might indicate the presence of a hand or foot. Madame Lachapelle declared she was never anxious when "the flat sac" was present, thereby meaning, says Cazeaux, that any "very great protrusion of it nearly always announces an unfavorable position."

CASE III.—*Vesical Distention Mistaken for Puerperal Peritonitis.*

This case was seen in consultation the seventh day of the puerperium. Multipara. Fever with abdominal pain and swelling began on the fourth day and ranged very high, notwithstanding the free employment of quinine. At the time of the consultation the temperature was above 104°; the pulse was very frequent and feeble, barely perceptible. There was considerable

tremor of hand and subsultus. The delirium was mild: the general aspect of the patient indicated speedy death.

The abdominal swelling had continuously increased from its beginning. The area of percussion flatness corresponded with the contour of a greatly distended bladder; beyond its limits the percussion note was tympanitic. Fluctuation was very distinct within the borders of the dull area. There was no pain or tenderness on pressure in any part of the abdomen. The nurse insisted that the patient had regularly passed water in sufficient quantity, and the attending physician had accepted her statements without suspicion of error. There was a strong urinous odor about the bed and person, probably attributable to the constant dribbling from an over-filled bladder. I drew off two quarts of high-colored, turbid, ammoniacal urine. After the evacuation of the bladder the abdominal walls were relaxed and flabby. The patient continued to sink and died during the succeeding night.

The title of this case is the expression of my own conviction of its nature. I believe the retention of urine had continued from her confinement, and that she died of acute toxemia. The enlargement of the abdomen had been observed, but had been supposed by the attending physician to be tympanitic distention. A careful inspection, percussion, and palpation would have made the diagnosis perfectly clear.

CASE IV.—Labor Pains Mistaken for the Pain of Vesical Repletion.

In describing the case of "fecal impaction obstructing labor" (AMER. JOURN. OBST., vol. XIX., p. 1,093) which I reported to this Society April 2d, 1886, I referred to the mistake of the patient in ascribing her distress and pains to inability to pass water when in fact she was in labor. I drew off four ounces of muddy urine, and, suspecting that I had not emptied the bladder, endeavored to ascertain the cause of the failure by vaginal examination, when I discovered the fecal mass filling the pelvis, and the dilated os with the bag of waters above the symphysis pubis. The recognition of these conditions absorbed my attention, and I did not again employ the catheter or attempt by palpation to verify or disprove the statement of the patient that she was suffering from retention of urine. I assumed, without consideration, that she was mistaken, and proceeded to break up and dislodge the fecal mass. When this was accomplished, the womb descended into the pelvis and labor progressed speedily to completion. About one hour afterwards she passed a very large quantity of urine, thus proving that I had failed to empty the bladder. This failure was due to the upward and forward displacement of that viscus and the impingement of the gravid uterus, which had been lifted out of the pelvis by the very large fecal mass which occupied it.

Her satisfactory recovery does not exclude the possibility of danger from vesical distention during labor. After having freed the rectum of the fecal accumulation, and the womb had descended into the pelvis, the condition of the bladder should have been ascertained either by catheterization or abdominal palpation. I recall your attention to this case because of the novel relation of the fecal mass in the rectum to the displaced parturient womb, and to the elevated and distended bladder, by which micturition was impeded and labor obstructed.

The following case presents vesical repletion in an equally novel but entirely different aspect.

CASE V.—*Cystocolpocoele*¹ *Complicating Pregnancy.*

During the early morning of November 24th, 1886, I received a note from a gentleman informing me that his wife was in labor, and requesting my immediate attendance. I found the lady, who was expecting to be confined the latter part of December, in great suffering, the pains seeming to be continuous with quickly recurring exacerbations. She insisted that they were labor pains. Proceeding to make a vaginal examination, the finger passed the ostium vaginae and with some force entered a tense, resilient pouch, apparently lined with a smooth, moist, mucous surface, the walls of which could be displaced by the movements of the finger to a limited extent laterally, upwards, and backwards (the patient lying upon her back), but always closing around the finger. I could not find the os, cervix, nor a presenting part; nor could I feel a cicatrix, a line of adhesion, or a point of induration. My suspicion was that the vagina had been obliterated by inflammatory adhesions. It was not an amniotic sac because of its uniform tenseness, the absence of hemispherical or elongated shape, and the impossibility of defining its contour by forcing the finger between it and the vaginal walls.

DECEMBER 21st, 1886.

¹“MY DEAR DOCTOR:—The term *cystocoele vaginalis* has been in use thirty or forty years, but it is objectionable as bringing a Greek and Latin term together. Cystocoele is, of course, Greek *κύστις* the bladder, and *κῆλη*, a tumor; but vaginalis is simply Latin. Nevertheless, it must be admitted that *cystocoele* is a Latinized form, and so the offence is palliated. I think it would be better to substitute for vaginalis the accepted Greek equivalent, *κόλπος*, which is commonly employed to signify the genital passage in the female. The term might be cystocolpocoele or colpocystocoele, the latter being more euphonious, but the first being more correct pathologically.

It is very common to preserve the *kappa* in words compounded with *κόλπος*, as kolporrhaphy, but I think if the Latinized form of *c* is used for *κύστις* and *κῆλη* it would be inconsistent to spell the new comer with a K.

Very truly yours,

ROBERT FLETCHER.”

After a careful and prolonged exploration, the patient all the time asserting that I was causing her increased pain, I desisted completely baffled. I knew that she had given birth to a male child two years before, and believed that she was now far advanced in her second pregnancy. She had always enjoyed good health, and neither she nor her husband had ever called my attention to any pelvic trouble. To gain time for reflection I walked the floor, talked with the nurse, and made many irrelevant inquiries of the patient. During this time I elicited the information that she had, during the previous day, three loose movements from her bowels, but had not passed water since the previous early afternoon, and I called to mind the methods of exploration by the rectum and abdomino-vaginal palpation. Thus reassured, I resumed the examination by the introduction of the index and middle fingers. The blind pouch, formed by the pressure of the fingers against the cyst, remained persistent and inexplicable. Then turning the palmar surfaces of the examining fingers towards the bladder, and gently tapping with the un-employed hand the abdomen above the pubis, within the area of vesical distention, I felt distinctly the wave of fluctuation against the fingers in the blind pouch, and the thought flashed through my mind that I was dealing with a distended bladder, prolapsed into and filling the pelvic cavity, obliterating the vagina and interposing a column of fluid within its tense walls, between the cervix uteri and ostium vaginae. I immediately directed the nurse to assist the patient to the commode, and then retired to the adjoining room to await the result. Upon my return, the nurse informed me that the patient had passed a very large quantity of urine, which had been emptied into the closet. The pain had ceased and the blind pouch had disappeared. The os and cervix could easily be reached. Labor had not begun. I advised the patient to go to sleep and forget the suffering of the four previous hours, and I reclined for the coming hour in peaceful relaxation upon a comfortable lounge.

This is to me an unique observation. Prolapse of the bladder during labor has been quite frequently witnessed. Such a complication may be caused by a pre-existing cystocele, previous protracted and difficult labors, inflammatory adhesions, habitual retention of urine, pressure of the head during the early period of labor upon the fundus or middle of the bladder when it is partially filled with urine, and constriction of the urethra from unusual elongation. Such descent of the bladder has been mistaken for a hydrocephalic head, a persistent amniotic sac, and an ovarian cyst; and in several instances it has either been incised or punctured, thus establishing a vesico-vaginal fistula.

It thus appears that in its diagnostic aspects I was dealing with a very grave complication. I supposed the patient was in labor, and if I had concluded the vesical prolapse to have been either of the conditions for which it has been mistaken I might have committed a very grave mistake and seriously injured the patient.

The case here reported differs from the cases of cystocolpocele complicating labor, in that it occurred a month previous to the labor and did not exhibit the usual subjective symptoms of that condition. It was characterized by pains not unlike labor pains and therefore the more deceptive, and by absence of the usual sensation of fulness and dragging, and constant painful desire with inability to pass water; tenesmus and dysuria were not only absent, but there was not even an inclination to urinate; and the bladder was evacuated with facility and ease when the patient was assisted to the commode. The negative symptoms were calculated to entice one into the errors that have been committed in somewhat similar cases.

The history of retention of urine, with tenesmus and dysuria, an abdominal tumor in the region of the bladder, and the detection of a fluctuating tumor in the vagina painful to pressure, and that can be evacuated by the urethra, constitute the essential signs of a correct diagnosis. With a knowledge of the possibility of such a displacement of the bladder and method of diagnosis no mistake would be excusable. It may happen, however, that an accumulation may take place without any vesical intumescence above the pubis. In that event, the discovery of a soft, fluctuating, and elastic tumor in the cavity of the pelvis, and its evacuation by the urethra, must be relied upon for a diagnosis. The condition of the bladder must be definitely ascertained.

CASE VI.—Puncture into the Pelvis of a Fetus with a Blunt Hook.

Madam X. was taken in labor June 20th, 1886. She had been in ill health for several years and was greatly distressed by the accidental death of her elder son. The labor progressed slowly, due to her feeble condition, constant apprehension of danger, the absence of efficient uterine contraction, and to a breech presentation. In consequence of the delay and supervening exhaustion, I determined to resort to artificial delivery under anesthesia, and invited Dr. Charles E. Hagner to assist me.

The breech presented, with extremities reflected on the trunk,

in right dorso-anterior position. After a futile attempt by traction with the finger over the fold of the right thigh, we decided to make an effort with the blunt hook. I passed the instrument from within out, with point towards the pelvis, over the fold of the right or pubic thigh and felt the end on the outer pelvic side. At my request, Dr. H. examined the adjustment of the instrument and, with the statement that it was all right, surrendered the handle to me. After continuing the traction for a while, only during the feeble pains, I felt a sudden jerk as if something had given way and heard an indistinct thud. Supposing I had fractured the thigh I reversed the hook and resumed the effort of traction, with a finger against the point between the thighs. Failing in these efforts, I brought down the legs and speedily completed the delivery. The child was born asphyxiated, but was resuscitated after considerable effort. The injury inflicted by the blunt hook consisted of a puncture through the abdominal wall above the ramus of the pubis, midway between the symphysis and inferior spinous process of the right ilium, penetrating the pelvis to the depth of three-fourths of an inch. The edges of the transverse slit through the integument were brought together by a suture and the wound was dressed antiseptically with a pledget of absorbent cotton dusted with iodoform. On the third day some pus oozed from the wound. The suture was cut out, the wound cleansed and dressed with dry absorbent cotton. The next day Dr. J. Ford Thompson saw the child and advised dressing daily with a narrow strip of iodoform gauze gently inserted into the wound and covered with a pledget of absorbent cotton. This treatment was followed with great care for two weeks without any apparent improvement. I then concluded that the method of dressing, which necessitated the frequent extension of the thigh, prevented reparation by gaping the wound, and substituted for it daily cleansing of the surface and a thin layer of dry absorbent cotton, with direction to the nurse to avoid any manipulation which might extend the thigh and open the wound. At the expiration of another week the wound was entirely healed, leaving only a linear cicatrix.

When discovered I regarded the injury as fatal, and so informed the father who replied, if that was so I ought to discontinue my efforts at resuscitation which I declined. From its birth to the completion of the cure the child never exhibited the slightest symptom or, in fact, any evidence of the reception of such an injury. The apprehension of injury to the bladder or rectum was dispelled by the absence, at the expiration of twenty-four hours, of any sign of damage to either of these organs.

This accident was the result of over-caution on my part. The displacement of the instrument must have occurred during the transfer from Dr. H. to me. I should either not have extended to my colleague the courtesy of an examination or, having done

so, should have requested him to proceed with the efforts at traction or, having resumed control of the instrument, should have re-examined the adjustment before proceeding.

This case was also complicated with adhesion of the placenta, which was delivered by Dr. H. The hemorrhage was controlled by hot-water intrauterine injections. Mother made a good recovery.

CASE VII.—Four Drachms of the Fluid Extract of Cascara given for an equal quantity of the Fluid Extract of Ergot.

At 11 p.m. Feb., 1882, I was invited by the late Dr. Beale to assist him in a case of protracted and difficult labor. The patient, a short, dumpy primipara, had been in active labor about twelve hours. The head presented in L. O. A. position and seemed to be arrested at the brim in the biparietal diameter. With the forceps the head was drawn into the cavity of the pelvis, but could not be delivered through the inferior outlet. After several ineffectual efforts with the forceps, I lifted the head from the pelvis, seized the feet, and attempted to accomplish delivery by version. I could not, however, force the head through the pelvic outlet by traction on the lower extremities, combined with suprapubic pressure and a finger in the mouth of the child. Forceps to the after-coming head were equally futile. I then passed the blunt hooked end of one blade of Hodge's forceps into the mouth of the child, and thus with traction on the extremities and the blade of the forceps completed delivery. The child was asphyxiated and could not be resuscitated. The expulsion of the placenta was followed by a profuse hemorrhage. A second drachm, the first having been given immediately after the delivery of the placenta, of the fluid supposed to be ergot, was promptly administered by Dr. Beale, and I grasped and firmly held the uterus. As soon as it could be obtained, a hot-water intrauterine injection was employed. The contraction which followed soon remitted and the hemorrhage returned. A third and a fourth drachm of the fluid extract was given, and the hot-water injections were repeated a second and a third time, but the temporary contractions of the womb were speedily succeeded by complete relaxation and recurrence of the hemorrhage. An hour or more elapsed during these ineffectual efforts to secure persistent uterine contraction when, worn out by the continuous stooping posture, with one hand grasping the womb and the other holding the nozzle of the syringe, I insisted that Dr. Beale had made a mistake or else the ergot was worthless. He replied that he had purchased it himself and that it was Squibb's preparation. Not satisfied, a messenger was dispatched to a druggist for Squibb's fluid extract of ergot. This was obtained and administered and soon permanent contraction was secured. The patient was made as comfortable as possible, and the necessary instructions were given to the nurse. When about to leave the house, Dr. Beale

discovered the bottle of ergot he had purchased in his overcoat pocket. He had given four drachms of the fluid extract of cascara within the period of one and a half hours. After a brief conference, it was decided that he should remain in the house during the remainder of the night and await developments. The convalescence of the patient was not disturbed by any of the ordinary discomforts of the puerperal period. Her bowels moved naturally on the third day and her recovery was speedy and complete.

This patient had a prolonged and difficult labor; was subjected to several ineffectual efforts at delivery with the forceps; then the head was lifted from the pelvis; the child was turned; delivery of the after-coming head by traction on the extremities combined with supra-pubic pressure failed, as did also the effort with the forceps to the after-coming head combined with traction by the extremities. Finally, delivery was accomplished by traction with the blunt hooked end of the blade of the forceps in the mouth of the child combined with supra-pubic pressure. Then followed a profuse and persistent hemorrhage, and the ineffectual efforts to secure permanent contraction of the uterus, during which four drachms of the fluid extract of cascara were administered; nevertheless, her convalescence was uninterrupted and recovery complete.

The usual rapid and satisfactory convalescence of lying-in women, upon whom the employment of hot-water intrauterine irrigation has been provoked by some grave complication of labor, has impressed me with the conviction that thorough washing out of the cavity of the womb after labor is the most effective preventive of certain puerperal disorders. I would not advocate it as a routine practice; nevertheless, I am so fully convinced of its value that I would advise it in every case of manual or instrumental delivery.

Traction with the blunt hook in the child's mouth is a novel procedure. I examined the condition of the mouth of the child very carefully, and could not detect any injury. It might have been otherwise in a living child. At the time the instrument was employed, I believed the child was dead, for considerable time had been expended in the previous futile efforts.

CASE VIII.—A drachm of Monse's Solution given instead of an equal quantity of the Fluid Extract of Ergot.

In November last, Madam X. miscarried during the sixth month of her third pregnancy. Directions were given to the nurse to administer a drachm of the fluid extract of ergot at 9 P.M., if neces-

ary. Very soon after that hour I was hastily summoned by the information that the nurse had given a drachm of Monsel's solution. The patient recognized the mistake immediately, and the nurse promptly administered a large potation of water. I found the patient perfectly calm, but complaining of a sense of weight and scalding in the stomach, with frequent very acid eructations, and a sharp taste of vinegar. Her pulse, temperature, and general condition were entirely satisfactory. I ordered hourly doses of a half ounce each of a solution of the bicarbonate of soda (prepared by dissolving one drachm in an ordinary goblet of water) until the acid eructation ceased; gum arabic water *ad libitum*; and, in the event of any disturbance of the bowels, one or more drachm doses of paregoric. Several hours after the solution of iron had been taken the patient vomited freely, and in quick succession had two copious liquid stools. The catharsis was checked by paregoric. No further trouble occurred. At my visit the next day the condition of the patient was in every way satisfactory. Her convalescence was uninterrupted.

